STATEMENT
OF
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ON
DISEASE MANAGEMENT IN TRADITIONAL MEDICARE
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

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Chairman Craig, Senator Breaux, distinguished Committee members – first, thank you for inviting me to discuss Medicare's attempts to use disease management to improve the care provided to its beneficiaries. As the delivery of health care has evolved, individual health care providers routinely plan and coordinate services within the realm of their own specialties or types of services. However, rarely does one particular provider have the resources or the ability to meet all of the needs of a chronically ill patient. Disease management is an arrangement in which some entity (a provider or a disease management organization) is responsible for coordinating all the health care services that are required to meet a patient's needs fully and in the most cost-effective manner. I want to discuss with you in greater detail the opportunities and challenges we face in integrating disease management concepts into Medicare. I can also describe our experience to date in developing and implementing demonstration projects designed to test alternative disease management approaches. We believe that these demonstration projects can help ensure that America's seniors and disabled beneficiaries receive the care they need both more effectively and more efficiently.

The Centers for Medicare & Medicaid Services (CMS) is determined to work constructively with Congress to achieve these goals. We are currently undertaking a series of disease management demonstration projects designed to explore a variety of ways to improve beneficiary care in traditional Medicare. We are looking to these programs to enhance our efforts to bring Medicare into the 21st Century and provide beneficiaries with greater choices, enhance the quality of their care, and offer better value for the dollars spent by beneficiaries and the government on health

care. We appreciate your efforts to strengthen and improve Medicare, and we look forward to working with you on efforts to make disease management services more widely available.

BACKGROUND

Beneficiaries with chronic conditions make up an increasing proportion of the Medicare population. According to a recent study (by the Johns Hopkins University's *Partnership for Solutions* project supported by the Robert Wood Johnson Foundation), 78% of Medicare beneficiaries have at least one chronic condition, accounting for 99% of Medicare fee-for-service spending each year; 20% of beneficiaries have at least five chronic conditions, accounting for 66% of fee-for-service spending. Moreover, patients with conditions such as asthma, diabetes, hypertension, congestive heart failure, and coronary artery disease typically receive fragmented health care from multiple providers and multiple sites of care; this problem is amplified for beneficiaries with multiple chronic conditions.

We need to find better ways to coordinate care for these patients. Not only is such disjointed care confusing and ultimately ineffective, it can present difficulties for patients, including an increased risk of medical errors. Additionally, the repeated hospitalizations that frequently accompany such care are extremely costly to both patients and Medicare. As the nation's population ages, the number of chronically ill Medicare beneficiaries is expected to grow dramatically, with serious implications for access, quality, and Medicare spending.

Through innovations in the private sector, managed care entities such as health maintenance organizations, as well as private insurers, disease management organizations, and academic medical centers have developed a wide array of programs that combine adherence to evidence-based medical practices with better coordination of care across providers. These initiatives are based on the belief that disease management programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes without increasing costs.

The greater prevalence of chronic illnesses among the Medicare population provides more opportunity for improving the appropriateness, effectiveness, and efficiency of care. In addition,

unlike private insurers, the Medicare program keeps its enrollees for life; that means that efforts to improve the coordination of care can be consistently and continuously applied over a long period, and it also means that the benefits from such efforts will accrue to the program, rather than potentially to some other payer. The demonstration projects conducted by CMS are intended to test the value of these programs.

Disease management and case management organizations provide services aimed at achieving one or more of the following goals:

- Improving access to services, including prevention services and necessary prescription drugs.
- Improving communication and coordination of services between patient, physician, disease management organization, and other providers.
- Improving physician performance through feedback and/or reports on the patient's progress in compliance with protocols.
- Improving patient self-care through such means as patient education, monitoring, and communication.

We are exploring a number of ways to pursue these goals in the Medicare program, while also gathering information on how best to make Medicare a more aggressive and effective purchaser of appropriate, high-quality care for its beneficiaries. One of the challenges of implementing our goals is encouraging providers to increase the utilization of disease management, which may present a departure from the current fee-for-service incentive structure. Developing an integrated-delivery system will allow the health care marketplace to evolve into a structure that more directly promotes care coordination and rewards quality.

WHERE WE ARE TODAY

In order to identify innovative ways to incorporate disease management services into the Medicare program, we have a number of demonstrations underway.

Coordinated Care Demonstration

We are currently implementing a demonstration in 15 sites – including commercial disease management vendors, academic medical centers, and other provider-based programs – to provide

case management and disease management services to Medicare fee-for-service beneficiaries with certain complex chronic conditions. These conditions include: congestive heart failure; heart, liver and lung diseases; diabetes; psychiatric disorders; Alzheimer's disease or other dementia; and cancer. This demonstration was authorized by the Balanced Budget Act of 1997 (BBA) to examine whether private sector case management tools adopted by health maintenance organizations, insurers, and academic medical centers to promote the use of evidence-based medical practices could be applied to fee-for-service beneficiaries. In a separate demonstration, Lovelace Health Systems in Albuquerque, New Mexico, is providing coordinated care services to Medicare beneficiaries with congestive heart failure or diabetes.

We are testing whether these coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among Medicare beneficiaries with chronic diseases. These initial projects are varied in their scope, include both provider organizations as well as commercial companies, utilize both case and disease management approaches, are located in both urban and rural areas, and provide a range of services from conventional case management to high-tech patient monitoring. In addition to Lovelace Health Systems, some of the sites we have selected include: Carle Foundation Hospital in Eastern Illinois; Medical Care Development in Maine; Health Quality Partners in Eastern Pennsylvania; and Washington University/Status One in St. Louis, Missouri.

As of October 2003, all of these plans have been in operation for at least one year. The plans have enrolled a total of 13,065 beneficiaries (6,693 in the intervention groups and 6,372 in the control groups). However, the five largest plans account for almost 60 percent of the total enrollment, while three plans have enrolled fewer than 100 beneficiaries in each of their intervention groups. Initial findings from the project indicate that beneficiary recruitment in the fee-for-service market can be a challenge. While the majority of plans has reached or is nearing enrollment targets, several plans have invested much more time and resources than they had initially expected to recruit beneficiaries. For example, while the most successful plans have a 40 to 45 percent acceptance rate, the enrollment rate at other sites is as low as 20 percent.

The most successful plans in terms of enrollment have had close ties to physicians and other providers. They also appear to be the plans that devoted significant effort to obtaining physician support for the program during the planning stages. Physician recommendations appear to be a significant factor in increasing enrollment rates. Due to concerns about fraud, beneficiaries are more likely to participate in a plan with a name they recognize. Although evaluation results are not available yet, the programs overall appear to be very well received by both enrolled beneficiaries and participating physicians. In addition, Mathematica Policy Research (MPR), the project evaluator, is beginning to collect and analyze the initial demonstration data. The first Report to Congress is due in the spring of 2004.

BIPA Disease Management Demonstration

An integral part of our overall strategy for testing disease management, this demonstration, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), was designed to determine whether providing disease management services to Medicare beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease can yield better patient outcomes without increasing program costs. As required by the legislation, the organizations participating in this demonstration will receive a fee not only for their services, but also for providing prescription drug coverage for all the drugs their enrollees are taking, whether or not they are related to their targeted chronic condition(s).

Coverage of prescription drugs is a unique aspect of this demonstration; it was designed to determine not only the impact on costs and health outcomes of offering disease management services, but also the impact of prescription drug coverage–which can be an important component of disease management strategies.

As specified in the legislation, aggregate Medicare payments, under the demonstration, must be less than they would have been in the absence of the demonstration and the sites have been required to guarantee savings to the Medicare program. CMS has selected CorSolutions of Buffalo Grove, Ill., Diabetex/XLHealth of Baltimore, Md., and The HeartPartners Group of Santa Ana, Calif. (a joint venture between PacifiCare, QMed, and Alere Medical) to participate in the BIPA demonstration project. The Office of Management and Budget approved the

Medicare waivers necessary to conduct the demonstration on October 17, 2003, clearing the way for the three sites to begin operations in January 2004.

Telemedicine

Another demonstration authorized by the BBA is our Informatics, Telemedicine, and Education demonstration. Currently, we have a 4-year cooperative agreement for a project aimed at evaluating the feasibility, acceptability, effectiveness, and cost-effectiveness of advanced computer and telecommunications technology to manage the care of Medicare and dually eligible beneficiaries with diabetes. Interim evaluations of the project have found that the recruitment phase was prolonged, due in part to difficulty recruiting primary physicians and retaining enrolled beneficiaries. As a result, recruitment efforts among physicians have been increased, and expanding the target geographic areas and relaxing non-critical medical exclusion criteria increased eligibility for participation in the demonstration. In addition, a steeper learning curve than anticipated exists among the beneficiaries, who generally had limited experience with computer technology. As a result, staff has focused on teaching patients how to use the technology.

Physician Group Practice Demonstration

Additionally, as required by BIPA, we are developing a physician group practice demonstration which will seek to encourage coordination of Part A and Part B services, reward physicians for improving health processes and outcomes, and promote efficiency through investment in administrative structure and process. Under the 3-year demonstration, physician groups will be paid on a fee-for-service basis and may earn a bonus from savings derived from improvements in patient management. Implementation is pending waiver approval and resolution of pre-implementation issues.

BUILDING FOR THE FUTURE

We are also considering future demonstration projects that will build on our past experiences, enhance the clinical management of the patients, provide for more effective coordination of services, and improve clinical outcomes. We are investigating how disease management projects could work with a diverse group of organizations in addition to disease management

organizations, such as integrated healthcare systems, and Medicare+Choice plans. Currently, we are reviewing applications for a Capitated Disease Management Demonstration, which will test our ability to encourage disease management interventions in capitated environments

This demonstration will apply a full risk-adjustment to the payment rates for participating organizations, which should encourage Medicare+Choice plans to consider participating in this demonstration. In addition, this demonstration encourages the formation of specialty plans that target beneficiaries with chronic illnesses, which currently is prohibited in M+C. We want to take advantage of the potential for coordinated care under capitated payment arrangements, to enhance the clinical management of care and improve beneficiaries' clinical outcomes without increasing costs to the Medicare program.

Another demonstration project will focus on beneficiaries with end-stage renal disease (ESRD). The demonstration will test the effectiveness of disease management models to increase quality of care for ESRD patients while ensuring that this care is provided more effectively and efficiently. Dialysis providers and disease management organizations will be able to participate. The demonstration will also be open to M+C organizations and integrated delivery systems. Solicitations for participation in the demonstration project were recently published in the *Federal Register* and we expect to implement this model next year.

EVALUATION

The objective of our evaluations is to assess the effectiveness of these programs for chronic medical conditions. In particular, we are evaluating health outcomes and beneficiary satisfaction, the cost-effectiveness of the projects for the Medicare program, provider satisfaction, and other quality and outcomes measures. Using a combination of surveys, administrative claims and enrollment data, and site visits, we will focus on the impact of the demonstrations on quality of care, outcomes, and costs. We will pay particular attention to the impact of the demonstrations on the following types of measures: mortality, hospitalization rates, emergency room use, satisfaction with care, changes in health status and functioning, and program expenditures. We will examine whether the disease management interventions result in less fragmentation in care for the given chronic conditions. Finally, we will examine which characteristics of disease management programs appear to be most effective in reducing

morbidity and improving quality of life for chronically ill Medicare beneficiaries. In each of these approaches, we expect that the costs to Medicare will be the same or lower through the efficiencies that will result in providing the most appropriate care. Through these demonstrations, we will continue testing and exploring new strategies for improving care and efficiency.

CONCLUSION

Disease management may have the potential for improving the nation's health care and its delivery system. We want to take full advantage of all of the opportunities for increased quality and efficiency that disease management offers. Unfortunately, seniors are far less likely than other Americans with reliable access to modern, integrated health care plans to have access to disease management services. Through our disease management demonstrations, we are working to give seniors the same access to modern disease management services that other Americans enjoy. We look forward to continuing to work cooperatively with you, Chairman Craig, Senator Breaux, this Committee, and the Congress, to find innovative and flexible ways to improve and strengthen the Medicare program while making sure that beneficiaries, particularly those with chronic conditions, have access to the care they deserve. I thank you for the opportunity to discuss this important topic today, and I am happy to answer your questions.